The Meaning of Coping for Psychiatric Patients

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Abstract

Contemporary psychiatric theory holds that a precipitant of major mental illness is the inability of some vulnerable individuals to cope with the difficulties of everyday life. Such mentally ill people are characterized as having deficient, dysfunctional, or absent coping skills. Recently, researchers have exerted considerable effort to distinguish between productive and nonproductive coping. In this article, we argue that not only are such conceptualizations reliant on reductive, circular logic but they also miss the essentially rational, local, and individual nature of coping in psychiatric patients' lives. We used semistructured interviews and thematic analyses of psychiatric patients' descriptions of their coping. Patients reported that professional intervention reduced their ability to cope, that they distrusted the mental health system and its professionals, that coping mechanisms were misinterpreted, that situational crises modulated coping, and that sometimes coping was just "not coping." We argue for a more respectful, nuanced understanding of coping among mental health professionals.

Keywords

coping and adaptation; interviews, semistructured; phenomenology; psychiatry; trust

It appears that a consensus in the literature has coalesced around the proposition that long-term stress leads both to adverse mental health states, such as anxiety and depression, and to physical illness, such as cardiovascular disease and type 2 diabetes (Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002). Although debate has raged about the relative contributions of intraindividual and socioeconomic factors in the development of individuals' capacities to manage stress, the weight of the evidence suggests that social factors play a major role. This influence is seen in both the degree of long-term stress with which individuals have to cope and in the abilities people have to manage, or cope with, these stressors, with concomitant inequalities in both physical and mental health outcomes (Adler & Matthews, 1994; Wilkinson & Pickett, 2009).

In psychology and psychiatry, the roots of coping research can be traced, arguably, back to Freud's work on defense mechanisms (see Freud, 1968) and Adler's reformulation of defenses as safeguards that serve to protect the self from external environmental threats (Ansbacher & Ansbacher, 1967). Although researchers have proposed many different theoretical models of coping in the last 30 years (e.g., Hobfoll's, 1989, multiaxial model; Lazarus's, 1966, transactional model), the field is plagued by the fact that coping has been understood, researched, and studied in different ways (Skinner, Edge, Altman, & Sherwood, 2003). To date, this diversity in approaches has not resulted in a coherent conceptualization regarding the nature of coping for those with mental illness.

Broadly speaking, two major approaches characterize the psychological literature on coping. The first, trait-based approach, has examined the effect personality variables have on individual coping capacity (e.g., Coan, 1973; McCrae, 1984; McCrae & Costa, 1986). Treatment of coping as a trait assumes that, once coping is in place, it presumably operates as a stable behavior. Therefore, the individual will cope in particular ways over his or her life course. The

second approach has concentrated on identifying and measuring the strategies people use to manage problematic situations (e.g., Carver, Scheier, & Weintraub, 1989; Endler & Parker, 1990; Frydenberg & Lewis, 1997; Moos, 1992). Consistent with this approach, coping is viewed as an essential aspect of the emotional process and emotional life. It is the relationship between an individual and the environment that determines the level of stress the individual experiences and what coping mechanisms he or she utilizes (Lazarus & Folkman, 1984). Through a process of primary appraisal, the individual assesses a situation as threatening, and then, through a secondary appraisal, the individual determines whether he or she has the resource strategies to cope. In this view (e.g., Lazarus, 1999), emotions are always a response to *relational meaning*: the person's sense of the harms and benefits in a particular person–environment relationship. This relational meaning determines the coping process.

The major approaches to coping vary in terms of the degree to which they take into consideration contextual variables. Some approaches are strongly contextualist (e.g., Holahan & Moos, 1987; Lazarus & Folkman, 1984), whereas others (e.g., Bodenmann, Charvoz, Widmer, & Bradbury, 2004) focus on individual-level variables. In particular, trait approaches give weight to personality characteristics (Coan, 1973; McCrae, 1984; McCrae & Costa, 1986) or individual and social resources (Holahan & Moos, 1987) such as optimism and social support (McColl, Hau, & Skinner, 1995; Taylor & Stanton, 2007). Under both approaches, however, coping is typically construed as the deployment of rational responses to objective problems. This view permits, ipso facto, the demarcation of adaptive and maladaptive coping and the presence or absence of coping skills or deficits. In contrast to the deficit focus of much of the psychological literature (cf. Rose, 1989), more recently, some researchers (e.g., Iwanaga, Yokoyama, & Seiwa, 2004; Keyes, 2007) have proposed that coping is better understood as a positive concept and

have focused on the use of adaptive strategies, building on an individual's strengths. It should also be noted that, historically, a minority position in the literature has recognized that maladaptive strategies can also be useful, if they help to manage stressors successfully (Menninger, 1963; Snyder, 1999).

Although the literature acknowledges major conceptual and methodological issues within the research and measurement of coping (e.g., Coyne & Gottlieb, 1996; De Ridder, 1997), currently the most popular method for measuring coping is quantitative, and the most common approaches are those derived from the work of Lazarus and colleagues (e.g., Lazarus & Folkman, 1984). In keeping with established critiques of mainstream social science methods (cf. Garfinkel, 1967; Schütz, 1962), Coyne and Gottlieb (1996) argued that coping theory and the associated checklist methodology obscure, where they do not minimize, important individual differences in how people manage stressful events. Thus, coping appears to be a more uniformly reflective, planned, and goal-oriented activity than it may actually be. In particular, standardized rating scales, such as the Ways of Coping Questionnaire (WAYS; Folkman & Lazarus, 1988) or the Coping Response Inventory (Moos, 1992), are unable to accommodate the fact that personal characteristics, history, and circumstances determine which incidents people report as being stressful. In addition, previous coping efforts influence the perception of novel stressful episodes an individual encounters, and the range of coping responses the individual employs may reflect how these episodes fit into the rest of the individual's current circumstances and history.

Consistent with these criticisms, Oakland and Ostell (1996) also noted that the efficacy of coping actions and the adequacy of external resources are two pivotal variables in the coping process, both of which are commonly overlooked in quantitative checklists. Moreover, an associated difficulty with the psychometric measurement of coping is that rating scales tend to

treat coping strategies as definable capacities (similar to, perhaps, short-term memory), of which persons may have greater or lesser amounts. As a consequence, by their cross-sectional nature, scales such as the Coping Scales for Adults (CSA; Frydenberg & Lewis, 1997) and the WAYS (Folkman & Lazarus, 1988), even when they claim to attempt to characterize coping as a process, fall back on intraindividual thoughts and actions and components of coping rather than conceiving of coping as an ongoing interactional process. For example, the WAYS identifies a set of eight distinct coping factors that, although eschewing the explicitly pejorative characterization of some strategies as nonproductive, and recognizing the importance of personal meaning, the seeking of support, and spiritual or religious dimensions to coping, still arguably conveys that some factors (or ways of coping) are superior to others.

With respect to coping in psychiatric populations, currently, dominant understandings of *mental disorder*, often referred to as *biopsychosocial* or *diathesis/vulnerability-stress* models (Read, Mosher, & Bentall, 2004), suggest that such disorders arise from the difficulty some (biologically vulnerable) individuals have in dealing with adversity. For these individuals, adverse life circumstances precipitate the onset of a putative biological (most commonly, it is suggested, neurochemical and/or genetic) disease process (Moncrieff, 2008; Taylor & Stanton, 2007). That is to say, those who are diagnosed as mentally ill are, it is claimed (and for a bewildering range of possible theoretical reasons), unable to cope with the "vicissitudes of life" (Summerfield, 2004, p. 233). That there is an inherently circular form of, essentially, folk reasoning at work here has not, it seems, obstructed the rise to near-total theoretical hegemony of this so-called model in contemporary psychiatry and (clinical) psychology (Boyle, 2011; Bracken & Thomas, 2005; Hansen, McHoul, & Rapley, 2003; Smith, 1978; Summerfield, 2006, 2008).

Smith (1978) clearly described an example of this circular reasoning, illustrating how patient “K” was diagnosed as mentally ill. The article reported on the gathering of information from various sources, the interpretations of others, and elements of K’s behavior, with the final judgment that K is mentally ill. In essence, how do we know that K is mentally ill? We know this because she cannot cope effectively with the challenges of everyday living. Why can she not cope effectively with the challenges of everyday living? We know this because she is mentally ill. This presents serious concerns, because, as Moncrieff (2010) suggested, once a psychiatric diagnosis is applied, it signals a need for various care actions and behavioral controls, which are presented as treatments. In the process, the patient is often overlooked, and, as Rapley, Moncrieff, and Dillon (2011) pointed out, “the social circumstances that cause or contribute to [the patient’s] suffering often go unexamined and unchallenged” (pp. 4–5).

When patients’ coping was measured psychometrically by the CSA, their coping strategies differed from those of other samples such as community and university samples (Ryan & Dziurawiec, 2013). The patients were more likely to respond by using what Frydenberg and Lewis (1997) described as nonproductive coping strategies such as ignoring problems, worrying, keeping to oneself, seeking spiritual support, and seeking professional help. They were less likely to engage in productive strategies such as focusing on solving the problem, working hard and achieving, or relaxing to deal with problems—what are, in effect, characteristics of the highly Westernized, gendered, and culture-bound version of the self-contained, rugged individualist. In essence, then, scales such as the CSA valorize a stereotypically masculine set of ways of dealing with problems in living (what, according to Barry, 1997, might be termed the “Marlboro man” approach—created via an extensive, 45-year-long advertising campaign, the image involved a rugged cowboy character with only a cigarette, to conjure up a masculine

image for filtered cigarettes). Such scales explicitly denigrate as nonproductive, a priori, ways of handling stressful life events that are more passive or that draw on interpersonal resources.

Quite aside from the concerns raised in the literature that the field of coping research is disappointing and has stagnated (Somerfield & McCrae, 2000), and the many, as yet unresolved, methodological issues in quantitative coping research (De Ridder, 1997), serious questions remain in the conceptual domain. How sensible is it to categorize peoples' attempts at coping? Can coping be sensibly described, a priori, as productive or unproductive? At what point does an attempt to cope become unproductive? Are broad categorizations of coping as productive or unproductive based on an empirical knowledge base, or are they, as they may appear, more like moral judgments than scientific evaluations? Indeed, can any particular coping strategy sensibly be labeled as effective or ineffective, productive or nonproductive, or even adaptive or maladaptive without reference to the context in which it is used? By what criteria are we to judge that some forms of coping are pathological or are symptoms of mental illness? A closer look at psychiatric inpatients' attempts to cope was needed. Furthermore, assumptions about symptomatology, pathology, and disorder needed to be suspended.

Method

We conducted a phenomenological investigation of the experience of coping as told by psychiatric inpatients. The study was part of a larger doctoral-study investigation, initiated in 2001, into coping in a psychiatric population. Via semistructured interviews and thematic analyses, we aimed to understand better what psychiatric patients find particularly challenging, how they cope with these challenges, and how these understandings of their coping call into question mainstream definitions of coping. The justification for this type of design was that it permitted us to capture more of the patients' experience of coping, without any preconceived

notions of what their coping abilities might be. In conducting this study, we gathered information about the various strategies patients use and do not use. We followed strategies for ensuring trustworthiness in qualitative research, such as credibility, transferability, dependability, and confirmability, as Shenton (2004) outlined. One great advantage of the methodology we used was that patients reported enjoying the experience of the interview, and therefore, as much as possible, we are confident that this article presents a true picture of the phenomenon of what coping means to patients.

Procedure

We conducted this study in a large, inpatient-only psychiatric hospital in Western Australia. The hospital offered no addiction, rehabilitation, or other specialty services. The setting for the interviews was a separate room in the research department of the hospital. The study adhered to all ethical guidelines, and we obtained approval for the study from the ethics committees of both the university and the psychiatric hospital. The first author approached psychiatrists and medical officers from throughout the hospital to request their patient lists. These medical professionals were not involved in the selection or interview process. Data collection took place over a period of 12 months.

We recruited participants throughout all wards of the hospital, with the exception of the long-stay ward, which contained many patients with severe neurocognitive deficits. The first author individually approached patients with information about the study and requested their consent to participate, subject to screening. Once a patient gave both verbal and signed consent to access to his or her medical files, we screened relevant information against the inclusion and exclusion criteria. All patients met the inclusion criteria, which were that the patient spoke English as his or her first language and that he or she had completed at least 15 years of

education. Exclusion criteria included deteriorating organic conditions and significant memory impairment (e.g., Alzheimer's disease or dementia). The first author made an appointment for an interview at a time convenient for each patient and, on the day of the interview, met the patient on the ward and escorted him or her to the interview room. At the conclusion of the interview, the first author escorted each participant back to the ward.

Participants

Thirty-eight patients, 25 men and 13 women, aged between 18 and 60 years, participated in the study. This sample size is around the mean number of subjects generally found in interview studies reported in the qualitative literature (Mason, 2010). Of the men, 16 had a diagnosis of schizophrenia, three of depression, five of bipolar disorder, and one of personality disorder. Among the women, six had a diagnosis of schizophrenia, two of depression, three of bipolar disorder, and two of personality disorder. We found in the review of the patients' medical files that they had been given many diagnoses—sometimes up to three or four different diagnoses over a period of 2 years—and multiple medications. The most recent long-standing diagnosis was the one used for this study. Patients had varying amounts of contact with inpatient mental health services, with the number of inpatient admissions ranging from between 1 and 5 (18 patients) to more than 25 (1 patient). In terms of their psychiatric histories, fewer than half of patients had received counseling or psychological intervention for their problems (10/38), all were currently in receipt of psychotropic medication, and the majority reported a history of illicit drug use (26/38) and, in some cases, multiple suicide attempts (28/38). In 16 cases, a family history of mental illness was reported.

Interview

The first author, who is an experienced psychologist, carried out the semistructured interviews,

which provided an opportunity for patients to talk in more detail about their difficult life experiences and their methods for coping with these experiences. Each patient completed an interview that took approximately 35 minutes. Interviews were brief to allow for low attention and concentration spans, which are often concomitant with various mental illnesses (Medalia & Revheim, 2002). The interviewer developed good rapport with all patients and informed them that there were no right or wrong answers to the questions, asked them to be honest in their responses, and made them aware that, at any stage, they could leave the interview or exit the research study. The interviewer provided patients with her contact details (e-mail address and telephone numbers) in case they wanted to discuss their own interviews or read and/or comment on their transcripts. Only two patients wanted to listen to their responses immediately after the interview, primarily to make sure that the researcher had recorded everything, but partly out of curiosity. Neither patient requested any edits to their recordings. Moreover, no patient left the study or later requested that his or her information be retracted.

Interview questions were as follows: What things do you find the most difficult to deal with in your life? Are there any particular situations that you find difficult to manage? (all of the patients identified at least one situation, and the interviewer noted all situations). What sorts of things do you do to manage difficult situations? (interviewer listed the patient's particular situations). When do you use the (various) approaches you have described? Which works best? When do the other approaches work best?

The first author audio-recorded and transcribed interviews verbatim. A professional secretary working in a mental health hospital, and with experience in transcription of doctors' audio recordings, also transcribed the interviews. A 100 percent agreement rate regarding content was achieved, with only minor variations in pauses and punctuation.

Analytic Procedure: Thematic Analysis

We adopted a phenomenological approach for the analysis of the interviews and used an inductive thematic analytical procedure, described by Hayes (1997) and elaborated by Braun and Clarke (2006). This approach allowed for a richer interpretation of the data and the capacity to assess underlying themes. We adopted strategies for ensuring the trustworthiness of the data, in accordance with Gubas constructs (see Shenton, 2004). The first author read and reread, noting initial ideas, and the second author, who had extensive experience in qualitative research, provided supervision of the process. The first author carefully scrutinized the interviews to identify meaningful units of text relevant to the questions posed about coping and then generated the initial codes, grouping units of text on the same issue together into analytical categories and giving provisional definitions. The same unit of text could be included in more than one category. Finally, after the first author completed the process of reviewing, defining, and naming the themes, the second author carried out a validity check. Both authors systematically reviewed the data to ensure that an exhaustive set of data supported each theme.

Results

We identified 12 categories organized into five superordinate themes. There was equal distribution of responses across all but one of the five themes. The five key themes were as follows: (a) a coping strategy was not a symptom of mental disorder; (b) coping was hindered by distrust in the mental health system and its professionals; (c) coping is related to meaningfulness, that is, being able to comprehend, manage, and attribute meaning to oneself and the world; (d) situational crises modulated coping strategies; and (e) “not coping” is a way of managing difficult situations. In the analysis that follows, we expand on the themes arising from this analysis. As such, what we offer is a necessarily selective discussion of pertinent instances of the

themes we identified.

Theme 1: A Coping Strategy Was Not a Symptom of Mental Disorder

Patients recounted a number of ways of managing difficulties in their lives. On the face of it, these coping strategies are describable as unproductive forms of coping or, more strongly, could be construed as symptomatic of the mental disorders with which patients have been diagnosed. Hence, the provision of fanciful narratives about managing difficulties might be readily redescribed as representing a departure from conventional reality testing and avoidance of, or retreating from, problems. For example, the use of drugs and alcohol might be construed as the type of socially avoidant and/or maladaptive behavior conceptualized as a secondary symptom of schizophrenia (American Psychiatric Association, 2013). We note that such interpretations are predicated on an a priori assumption of patienthood, a perspective that conditions explanation. Here we suggest that, if we suspend judgment and examine patients' accounts in their own terms, some rather different understandings of their accounts become possible. That is to say, there is a choice to be made about the meaning that is attributed to the reports patients make about their experiences.

In the following extract, a patient describes the techniques he used to handle the experience of hearing voices:

> Interviewer (I): Does this happen before, before you have a relapse?
>
> Patient (P): No, I just feel a bit sick and it gets worse and worse. I just lay up in my bedroom and wait for it to pass.
>
> I: So you just feel a bit sick.
>
> P: Not physically sick.
>
> I: Can you explain that situation to me?

P: Well, I hear voices and I get disoriented. Disoriented or orientated, what is it?

I: Disoriented. Oriented means you are aware of your time and place.

P: That's what I thought.

I: When you say you get disoriented, do you mean you don't know where you are?

P: Yes. I don't know what day it is, I don't know what week it is. I know where I am, but I just lock myself away in my bedroom until it's passed.

I: Does that work? Have you used this in the past to help manage that?

P: Yeah.

I: How long do you lock yourself away?

P: Until it's over, four hours, five hours.

I: Can you tell me about that?

P: If I get very bad, I take PRN, which is a very strong dose of droperidol, which helps a bit but gives me a lot of side effects. That's another reason for locking myself away.

I: So you don't just lock yourself away, you take PRN before you do that?

P: Yes.

The patient's way of managing his distressing experience by locking himself away for 4 or 5 hours is presented as a tried-and-tested coping mechanism. This type of behavior could be describable as avoidant or unproductive coping and is potentially categorizable as a variety of the social withdrawal (or asociality) considered to be a symptom of serious mental illness under prevailing nosologies (American Psychiatric Association, 2013). Alternatively, it is understandable as a perfectly sensible and efficacious way of dealing with feeling sick and disoriented. We note that his description of his way of dealing with voices is, semantically and

prosodically, matter of fact and businesslike: there is no sense of floridity or reality distortion in his description.

A similar interpretation is applicable to the following exchange, in which another patient fluently describes the strategies she uses to manage both her mental health difficulties and associated illicit drug use:

I: So what sorts of things do you do to manage these situations?

P: Just taking every day as it comes. Just prove to myself that I can stay off the drugs and keep clean. Remember my time in [the psychiatric hospital] without them. My sadness, my rehabilitation, my detox. Medication that I've found to substitute those drugs. The stages like I said for the butterfly. From the caterpillar to the egg, from the egg to the caterpillar and now the egg to the butterfly and now I'm reaching out and I'm going to fly off and spread my wings. That's my strategy for how I'm going to handle this.

I: Can you just tell me a little bit about that?

P: I'm the egg. I felt like I was in a stocking trying to get out, like in theater arts where you see people reaching out and struggling and trying to get out of that stocking. That's how I felt before I went through detox. Now I feel I've broken out of that and I'm going to change into a butterfly. I don't live on anxieties anymore. I used to at one stage of my life but that's when I was depressed and lonely but now I have to just go with the flow.

I: Which strategy do you use now and works the best?

P: The butterfly strategy.

I: Do the others work?

P: That's the only one that I can see clearly that means something to me.

The patient clearly articulates three ways of dealing with her difficulties. These are her own, self-developed coping mechanisms. It is of note that three of the approaches identified are analogous to established psychotherapeutic interventions: first, what might be otherwise described as cognitive coping strategies, that is, "taking every day as it comes," "proving to myself that I can stay off the drugs and keep clean," "remembering" successful withdrawal; second, using medication appropriately; and third, employing an approach akin to narrative therapy, providing a metaphorical restorying of her recovery. In an account reminiscent of Laing's (1960) description of a study of a chronic schizophrenic called "Ghost of the Weed Garden" in his book *The Divided Self: An Existential Study in Insanity and Madness*, the patient uses the extended metaphor of metamorphosis to help the interviewer understand her experience.

McCabe, Heath, Burns, and Priebe (2002) suggested that the standard psychiatric injunction not to engage with the detailed concerns and content of psychotic patients' talk is, indeed, routine practice. Assertions such as "I'm going to change into a butterfly" are, in everyday psychiatric practice, less likely to be taken metaphorically and more likely to be viewed as delusional. As with the avoidance strategies described by the first extract, however, the account this patient offers is clear and insightful. To characterize either of these patients' ways of coping as other than effective, for them, is to misconstrue their experiences.

Theme 2: Coping Was Hindered by Distrust in the Approach of the Mental Health System and Its Professionals

Across all patients' accounts, the ability to cope with their difficulties was strongly related to levels of distrust in the mental health system and the professionals working in it. This theme revealed barriers to patient coping and cast doubt on what is considered by mainstream psychiatry and psychology to facilitate coping. In all interviews, patients described hospital

stays, particularly after involuntary admission, and psychiatrists, with their systemic reliance on physical treatments, with medication as a first line of treatment and the routine use of electroconvulsive therapy (ECT; commonly used as a treatment option for so-called drug-resistant depression and often for older people with depression; see Newnes, 2011), as unhelpful and not supportive of their own coping.

Indeed, a number of informants suggested that their interaction with mental health services decreased their sense that they were able to cope with their difficulties, instead promoting a sense of learned helplessness. As described previously in a patient's extract under Theme 1, the medication prescribed to assist him to cope with his mental health problems had effects that produced additional difficulties with which he then had to cope. Although, for this patient, the strong dose of droperidol "helps a bit," the side effects it induces, paradoxically, augment his perception that he needs to use avoidance as a strategy to manage his problems. Here, then, we can see the unintended iatrogenic consequences of psychiatric intervention: nonproductive coping strategies being fostered by interventions intended to ameliorate the difficulties warranting the intervention in the first place.

Similarly, another patient's experience illustrates the way in which, although he describes his psychiatric medication regime as helpful, he is reduced to the nonproductive strategy of wishful thinking, simply "hoping I'll get better," in the face of professional ignorance about ways to help him cope with his impotence:

I: What things do you find the most difficult to deal with in your life?

P: Impotence.

I: What situations do you find difficult to manage?

P: Mundane day-to-day activities.

I: What are you doing to manage your impotence?

P: I can't manage it. It's beyond the pale.

I: Do you take much medication at the moment?

P: Heaps of things. I'm on olanzapine, that's an antipsychotic. I'm on sertraline, that's an antidepressant. I'm on clonazepam and diazepam, they're both tranquilizers, for antianxiety. I'm on anti–gastric reflux. Occasionally I'm on Epidrin, which is antimigraine. I'm on procylclidine, which is antiakathisia. I think that's the lot but there may be something else.

I: Have you tried to do anything else?

P: I've tried to masturbate myself . . . It makes me feel low self-esteem.

I: Have you talked about it in your men's groups?

P: I've told my psychiatrists here. They didn't know how to deal with it but said they are going to ring around to see if there are any specialists who could help me. I've got no further than that.

The finding here that patients need to cope with side effects of their medication, in addition to the difficulties for which the medication is prescribed, is consistent with Jablensky et al.'s (1999) finding that 63.2% of respondents to their Australian national mental health survey described specific side effects of medication and believed that these side effects impaired their daily lives. Researchers in a subsequent study in 2010 established that three-quarters of participants (77.4%) complained of medication side effects and that three-fifths (61%) suffered impairment in their daily lives as a result of these medication side effects (Morgan et al., 2012).

For some of the patients, if professional help in the form of medication was seen as

limited, more assertive interventions were seen as being positively countertherapeutic. In the following extract, another patient describes situations he finds difficult to manage:

> I: Are there any difficult situations you find difficult to manage?
>
> P: In particular, being locked in Admissions East and people are being dragged in kicking and screaming, throwing themselves against walls, or shitting themselves at nighttime. Having to explain myself over and over again. Being accountable for every minute of every day. I don't pry into other people's lives. I'm just constantly repeating myself.

In addition to unpleasant physical surroundings, deprivation of liberty, and the distressing experience of witnessing "people . . . being dragged in kicking and screaming," the patient's account draws attention to another feature found repeatedly in the interviews, namely, the difficulties patients had in their interactions with mental health professionals. Whereas for this patient, the issue was having to explain himself over and over again, being accountable for every minute of every day, and constantly repeating himself, many other respondents reported not trusting health professionals, not trusting professional advice, and not being heard by their treating psychiatrists. Another patient reported that she felt her psychiatrist thought she was lying and, since her hospital admission, she had found out that things she had spoken about confidentially with her psychiatrist had not remained confidential. She reported, "I'm having second thoughts about psychiatrists now, only because I always thought a psychiatrist was like a doctor, confidential, but I was told it's not, it's not like a [general practitioner] being a psychiatrist."

The lack of congruence between individuals' understandings of themselves and mental health professionals' diagnostic perceptions of the individuals was a topic that the patients

frequently raised. When asked what the most difficult things to deal with were, another patient reported that she could cope with most problems but not with being called crazy. As she said, "I'm not crazy, they put me down crazy, but I'm not crazy." As such, when discussing what strategies helped them with coping, patients reported that, because many mental health professionals saw them unidimensionally, medication did not always help, and ECT did not make them "better." Paradoxically, some patients were rendered helpless by the mental health system. Patients repeatedly reported how disheartening they found the experience of putting their faith and trust in the mental health system and in professionals, only to be given a label and left with a so-called cure (medication or ECT) that did not work.

In addition, a number of patients suggested that they had let important people down, or "failed" them, by being admitted to the hospital. Indeed, for several of the women interviewed, being involuntarily separated from family and children was not perceived as an aid to recovery. Rather, as one patient mentioned, it was looking forward to leaving the hospital that gave him hope and enabled him to cope with the additional trauma of compulsory hospitalization. As he said, "I know I'm not a danger to myself and others. I just want to get on with my life. A normal life. Everyone's wondering where the hell I am, lecturers, cricket planning, being locked in here is compounding the problem." Another patient's estimation of her situation seemed to sum up this dilemma clearly: "I know I have to help myself, the tablets aren't going to do it, the ECT isn't going to do it. I don't know if I'm strong enough to do it either."

The interview responses as a whole suggest, for these patients at least, that their repeated exposure to the mental health system has decreased their confidence in their coping skills and increased a sense of helplessness. Patients repeatedly offered accounts of "putting up with hospital," "going along with [treatment]," and "doing nothing" while hospitalized. They also

described using (what the coping literature characterizes as nonproductive) coping strategies, such as wishful thinking, hope, and passivity, to help them endure their situations.

Theme 3: Coping Is Being Able to Comprehend, Manage, and Find Meaning in Self and the World

Across all interviews, patients described coping as enhanced or, conversely, as compromised by a small number of common factors. Patients indicated that when they experienced the world as predictable, understandable, and structured, they felt that they had adequate personal resources to meet the demands placed on them by circumstances, that they and their lives made a contribution to others (that they were worthwhile), that they had their difficulties heard and construed as "normal," that they experienced self-esteem, and that their coping abilities were enhanced. Conversely, when their experience of the world ran contrary to this (and, as we have seen, many patients' experiences of mental health services consisted of precisely this), they reported that their capacity to cope was severely attenuated.

Patients' experiences of mental health services were largely experiences of being passive and, not infrequently, unwilling recipients of treatment. In response to the question, "What do you find most difficult to deal with in life?" one patient reported,

> Probably having a psychiatric illness. At times I find that hard to deal with. Just I don't know if you'd call it embarrassing just having that label, saying the words *schizophrenia* and *psychosis* is a bit heavy for people to fathom or understand. Some people understand it better than others and I find that quite difficult . . . Sometimes you have your good days and your bad days, and when you have your bad days sometimes you want to be in total isolation away from people and they sometimes don't understand that you just want to be alone and you don't want to offend them or be offensive toward them.

Patients described wanting to be able to comprehend, manage, and find meaningfulness in their experiences and the world around them, just as everyone always tries to make sense of his or her predicaments. As Rowe (2003) described this quest for meaning, "we give our world meaning and we act in accordance with that meaning" (p. 174). One of the difficulties facing patients was the understanding of their illness by spouses and/or family members. In keeping with these concerns, many patients claimed that they would be careful about with whom they discussed their illnesses and that, most of the time, they omitted details, making it easier to understand, in an effort not to burden their spouses, families, and friends. As one patient explained, "trying to cope with the label and illness . . . it is about sort of easing into it with people, not telling them the full scope and complexity of the illness." But when queried about what most helped them cope with their difficulties, patients also reported that talking to people whom they trusted or whom they felt could shed some objective light on their situation was helpful. This process added meaningfulness to their situation and sense of themselves. As this patient observed, "for me, relaxing or speaking to a close friend. Having a chat to someone who can shed some light onto a few problems you're having at the time. That works best."

In addition to seeking support from friends and family, a number of patients described a range of strategies they used to add meaning and achievement to their lives as a way of coping with mental health difficulties. In the following extract, a patient describes his own, active strategies for dealing with his suicidal thoughts:

> I: If I were to ask you what strategy you use that works the best, what would you say?
>
> P: Now that we're sitting here talking, I realize how strong the poetry is, because it also enables me to think wow I've written five pages, I feel good. I've done something. So on

> top of everything else it's an accomplishment. So I'd probably say that stands quite high up on the list. In my bedroom it would be different. It depends what I'm coping with. Suicidal thoughts or something like that is very difficult to come out of. Then I have to have layer upon layer, I have to have a bath, have the essential oils, I have to do some meditation, I have to pray.

We are struck by both the very mundane nature of the strategies identified by the patients in these interviews—seeking support from understanding friends, attempting to secure objective advice, adopting self-care strategies such as meditation and relaxation techniques—and also the very real difficulties that being identified as mentally ill caused for patients in adopting these coping strategies. Also of note, we suggest, is the very articulate and insightful way in which patients were able to describe both the coping mechanisms they found helpful and the barriers to their use that diagnosis posed.

Theme 4: Situational Crises Modulated Coping Strategies

Across all interviews, patients reported that their usual coping styles were affected by situational crises, leading to an increase in the need for coping strategies and adaptation of strategies and, for some, admission to hospital. The deployment of certain coping strategies and the need for coping depended on the seriousness of the circumstances. Patients adapted their coping strategies depending on the severity of their life events. Of note here is that most of the patients interviewed described abhorrent life circumstances with which few people would have coped. As Newnes (in press) emphasized, the material context of peoples' lives needs to be recognized:

> Talking treatments are *bound* to kill a little of the spirit, *despite* the best intentions of patient and psychologist; talk is neither going to change the context of the patient's life

nor—necessarily lead to the patient gaining the power essential to change, a fairly dispiriting outcome.

One patient described having to "adapt" her coping style for many years after her partner went to prison, and, at the same time, she was embroiled in legal proceedings against her parents. Her partner was her major source of support over the years, to help her cope with the anxiety with which she had been left from being repeatedly sexually and physically abused by both her parents for 28 years of her life. When asked what she found difficult to deal with in her life, she described the following:

P: Loss of my children. My partner being in prison I guess, it's hard when he's not around. Legal proceedings. The list goes on.

I: What sorts of things do you do to manage these difficult situations?

P: I have very little coping mechanisms, I don't cope well. I don't have any stress triggers, like I don't have any signs that I'm under stress and when I do erupt it's usually a self-mutilation of some sort or it's suicidal attempts but there's no sort of sign in between. It's either I feel really fine or I feel suicidal and there's nothing in between.

I: Which strategy works best for you?

P: Accepting it. When I accept it, I basically let go of the situation, I believe it's out of my hands and I just let it go. I'm not in a secure, stable position to fight for any rights and until I'm home based and settled I've got nothing to stand on to fight with so I have to accept it and let it lie for now but I don't think I'll leave it at that forever. That's just a temporary measure to cope so that I can cope with life.

This patient's voluntary hospital admission occurred after she began self-mutilation. She

then reports accepting her situation, and this helped her cope. Bridgett and Polak (2003) reported that a crisis leading to a hospital admission is defined as when a patient has exhausted his or her coping resources and support from others. For the majority of patients interviewed, a suicide attempt had preceded an admission to the hospital. Many patients reported serious life events (both past and present) that had led to an increase in the utilization of coping strategies, thoughts of suicidality, and a subsequent hospital admission.

Patient accounts that led to emergency admissions were usually preceded by a situational crisis, such as relationship breakdown and loss of contact with family, significant other, children, and loved ones. Other patients spoke of situations in which insidious trauma that dominated their lives had become intolerable. They described engaging in a variety of behaviors, ranging from dangerous to sabotaging, to cope with situational crises. Patients described "serious" situations, outside of, by their definition, normal experiences, that they saw as requiring drastic measures. One patient reported that he jumped in front of a train as an attempt to cope with a relationship breakdown: "I just got sick of relationships breaking down. You build things up and they just keep falling down. It's like why should I try? If you try you get hurt, so why bother?" Bridgett and Polak (2003) have highlighted that a hospital admission, once seen as a necessary resource for dealing with a situation in which alternative resources have been exhausted, now carries, at least for some, the side effect of being taken from the social context and medicalized.

Theme 5: "Not Coping" as a Way of Coping

Dillon (2011) outlined ways in which dissociation, consequent on severely traumatizing life experiences, may function as a self-protection (or coping) strategy. In the interviews discussed in this article, many patients similarly reported dealing with their distressing experiences simply by accepting the fact that not coping with them was, in and of itself, an effective strategy for dealing

with overwhelming circumstances. That is to say, some patients actively and consciously rejected the societal expectations of rugged individualism, which is the essence of normal in the academic coping literature. In essence, we see the embrace of not coping as a coping mechanism.

Patients reported various strategies that would be categorized as unproductive coping mechanisms by instruments such as the CSA. As the interviews show, some patients would engage, for example, in binge drinking to manage a crisis, and then return to their regular routines. Some patients reported a powerful sense of guilt, having been told by mental health workers that this type of strategy was inappropriate, which then necessitated additional emotional and psychological resourcefulness to cope with the guilt induced by such professional advice. The variety of supports reported most frequently to help get through difficult situations were religion, alcohol, and prescription and illicit drugs, which Malow, West, Williams, and Sutker (1989) argued to all be means of self-medicating. Indeed, patients displayed acute insight into the fact that their inappropriate use of alcohol or drugs was a strategy to cope with particular situations at particular points in time. As one patient put it,

> I've been doing a lot of drugs. Chases the demons away. Puts you into a different state of mind so that you're not thinking about why you're taking the drugs, you're just enjoying the drugs you're taking. You're just escaping the reason not the cause . . . that's my way of coping, shut the world out.

Another patient described how "not coping" actually helps her "cope." Her response to the question, "What helps you to cope?" illustrates this clearly:

> My husband. . . . Now I can say, "I feel like shit" and go back to bed or say, "I want to go home" and we'll go. I know that if I'm in bed the kids will have a cooked meal for them.

He's allowing me to have a breakdown and learn to cope and to not cope when I can't cope.

Conclusion

To our knowledge, this study is the first to reveal the personal accounts of the many ways in which psychiatric patients cope with the difficulties with which they are faced. Among some patients, a style of coping was evident that is reflective of stable coping strategies (McCrae & Costa, 1986). The majority of patients used a combination of coping mechanisms, which is more in keeping with Lazarus's theory of coping. Patients' accounts of coping reflected the relational meaning between themselves and their environments, which affected the levels of stress they experienced and their subsequent coping processes (Lazarus & Folkman, 1984). In some instances, their accounts illuminated the barriers to their coping, which calls into question what mainstream psychiatry and psychology consider as facilitative of coping. We identified five themes that cohere around the problems inherent in the definitions of coping imposed by others in their environment. These definitional impositions negatively affect patients' experiences of self and their views of their own coping strategies.

Underlying many patients' reports of difficulty in coping with their problems was a sense of confusion over the issue of their personal agency consequent on diagnosis, multiple problems induced by a systemic reliance on physical treatments in mental health services, and the diminution by professional helpers of their personal resources for coping with distress. Feelings of worthlessness and decreased self-esteem engendered by contact, often involuntary, with mental health services were associated with poorer coping responses. Patients consistently reported being frustrated by not being heard by service providers and that their experiences

with services did not add meaning to their lives.

Summerfield (2004) argued that underpinning the construct of mental health is the concept of the person, which contains questions such as, What can someone be faced with and still be normal? What is acceptable behavior in a time of crisis? The idea of the person in current Western society now focuses not on resilience but on vulnerability, which leads to a "blurring between unpleasant but everyday mental states and those suggesting a clinical syndrome" (Summerfield & Veale, 2008, p. 327). This notion of pathologizing normal, everyday behavior, for example, marital problems or bereavement, requiring mental health professional intervention has severe consequences on how the individual views his or her own coping, "even when the person concerned has lived a competent life to date and has never demonstrated vulnerability to mental disturbance" (Summerfield, 2004, p. 233). There are also cultural implications with too narrow a view of what constitutes coping for those with mental health issues. What is seen as culturally appropriate in one group may be viewed as vastly different in another. This echoes Summerfield's (2008) argument that the globalization of mental health is fraught with issues and sets out "to instruct, regulate, and modernize, presenting as definitive the contemporary Western way of being a person" (p. 992).

As we explored the meaning of coping with psychiatric inpatients, the difficulties they face, and how they "do" coping, one feature emerged repeatedly: professional intervention in the form of diagnosis, as opposed to understanding patients as people experiencing "problems in living," reduced informants' ability to cope. Relatedly, patients repeatedly provided accounts of experiences in which professionals misinterpreted coping strategies as symptoms of illness, rather than as the best attempts the patients could muster to manage their difficulties. What was important for patients was to find someone who could be trusted, who could help them to make

sense of what they were experiencing without judgment. This, however, was a service that was not provided, or facilitated, by the mental health system in which the patients were enmeshed. This outcome resulted in the patients' lack of trust in mental health services and in the professionals working in them, which in turn led to additional difficulties in coping. Most of the patients interviewed saw themselves as members of the community dealing with everyday life events such as love, loss, and relationship breakdown. This sometimes led to successful coping, meaning, on occasion, not coping—a strategy that patients were able to clearly articulate.

Bentall (1992) elegantly demonstrated that the criteria psychiatry employs to define some forms of conduct as pathological are, and can only be, moral ones. Similarly, what does or does not count as helpful, healthy, or appropriate means of dealing with problems, that is, coping strategies, cannot but be a matter of local and individual, rather than universal, definition. As such, we suggest, not only is the global notion of inadequate coping in and of itself a totalizing moral judgment but also the notion that ways of coping, which attract the opprobrium of psychiatry, are in some meaningful sense "symptomatic" of a "mental disorder" is inherently tautologous and, hence, meaningless. Even were this not the case, it is our contention that the ways of managing often traumatic life circumstances, described by the patients in this study, are not only essentially comprehensible but also often creative and courageous. To describe such ways of coping as "nonproductive," or as "symptoms" of "mental disorder," is, we suggest (pace Sarbin & Mancuso, 1984), not to arrive at a medical diagnosis but rather to pass pejorative moral judgment.

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